§ 447.78 Aggregate limits on alternative premiums and cost sharing.

(a) The total aggregate amount of premiums and cost sharing imposed under sections 1916 and 1916A of the Act for all individuals in a family enrolled in Medicaid with family income above 100 percent of the FPL may not exceed 5 percent of the family's income for the monthly or quarterly period, as specified by the State in the State plan.

(b) The total aggregate amount of cost sharing imposed under sections 1916 and 1916A of the Act for all individuals in a family enrolled in Medicaid with family income at or below 100 percent of the FPL may not exceed 5 percent of the family's income for the monthly or quarterly period, as specified by the State in the State plan.

(c) Family income shall be determined in a manner, for such period, and at such periodicity as specified by the State in the State plan, including the use of such disregards as the State may provide and the process for individuals to request a reassessment of the family's aggregate limit if the family's income is reduced or if eligibility is being terminated due to nonpayment of a premium.

(1) States may use gross income or any other methodology.

(2) States may use a different methodology for determining the family's income to which the 5 percent aggregate limit is applied than is used for determining income eligibility.

[75 FR 30264, May 28, 2010]

§ 447.80 Enforceability of alternative premiums and cost sharing.

(a) With respect to alternative premiums, a State may do the following:

(1) Require a group or groups of individuals to prepay.

(2) Terminate an individual from medical assistance on the basis of failure to pay for 60 days or more.

(3) Waive payment of a premium in any case where the State determines that requiring the payment would create an undue hardship for the individual.

(b) With respect to alternative cost sharing, a State may amend its Medicaid State plan to permit a provider, including a pharmacy or hospital, to require an individual, as a condition for receiving the item or service, to pay the cost sharing charge, except as specified in paragraphs (b)(1) through (3) of this section.

(1) A provider, including a pharmacy and a hospital, may not require an individual whose family income is at or below 100 percent of the FPL to pay the cost sharing charge as a condition of receiving the service.

(2) A hospital that has determined after an appropriate medical screening pursuant to §489.24 of this chapter, that an individual does not need emergency services as defined at section 1932(b)(2) of the Act and §438.114(a), before providing treatment and imposing alternative cost sharing on an individual in accordance with §447.72(b)(2) and §447.74(b) of this chapter for non-emergency services as defined in section 1916A(e)(4)(A) of the Act, must provide:

(i) The name and location of an available and accessible alternate non-emergency services provider, as defined in section 1916A(e)(4)(B) of the Act.

(ii) Information that the alternate provider can provide the services in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing.

(iii) A referral to coordinate scheduling of treatment by this provider.

(3) The provider is not prohibited by this authority from choosing to reduce or waive cost sharing on a case-by-case basis.

(c) Nothing in paragraph (b)(2) of this section shall be construed to:

(1) Limit a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or

(2) Modify any obligations under either State or Federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency medical services by any managed care organization.

[73 FR 71851, Nov. 25, 2008, as amended at 75 FR 30265, May 28, 2010]

§ 447.82 Restrictions on payments to providers.

(a) The plan must provide that the State Medicaid agency reduces the

payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider successfully collects the cost sharing.

(b) Payment that is due under Medicaid to an Indian health care provider or a health care provider through referral under contract health services for directly furnishing an item or service to an Indian may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deductible, copayment, cost sharing, or similar charge that otherwise would be due.

(c) The plan must describe how the State identifies for providers, ideally through the use of the automated systems, whether cost sharing for a specific item or service may be imposed on an individual beneficiary and whether the provider may require the beneficiary, as a condition for receiving the item or service, to pay the cost sharing charge.

[75 FR 30265, May 28, 2010]

ALTERNATIVE PREMIUMS AND COST SHARING UNDER SECTION 1916A

§ 447.88 Options for claiming FFP payment for section 1920A presumptive eligibility medical assistance payments.

(a) The FMAP rate for medical assistance payments made available to a child during a presumptive eligibility period under section 1920A of the Act is the regular FMAP under title XIX, based on the category of medical assistance; that is, the enhanced FMAP is not available for section 1920A presumptive eligibility expenditures.

(b) States have the following 3 options for identifying Medicaid section 1920A presumptive eligibility expenditures and the application of payments for those expenditures:

(1) A State may identify Medicaid section 1920A presumptive eligibility expenditures in the quarter expended with no further adjustment based on the results of a subsequent actual eligibility determination (if any).

(2) A State may identify Medicaid section 1920A presumptive eligibility expenditures in the quarter expended but may adjust reported expenditures based on results of the actual eligibility determination (if any) to reflect the actual eligibility status of the individual, if other than presumptively eligible.

(3) A State may elect to delay submission of claims for payments of section 1920A presumptive eligibility expenditures until after the actual eligibility determination (if any) is made and, at that time identify such expenditures based on the actual eligibility status of individuals if other than presumptively eligible. At that time, the State would, as appropriate, recategorize the medical assistance expenditures made during the section 1920A presumptive eligibility period based on the results of the actual eligibility determination, and claim them appropriately.

[65 FR 33622, May 24, 2000]

Subpart B—Payment Methods: General Provisions

§ 447.200 Basis and purpose.

This subpart prescribes State plan requirements for setting payment rates to implement, in part, section 1902(a)(30) of the Act, which requires that payments for services be consistent with efficiency, economy, and quality of care.

[46 FR 48560, Oct. 1, 1981]

§ 447.201 State plan requirements.

(a) A State plan must provide that the requirements in this subpart are met.

(b) The plan must describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program.

§ 447.202 Audits.

The Medicaid agency must assure appropriate audit of records if payment is based on costs of services or on a fee plus cost of materials.

§ 447.203 Documentation of payment rates.

(a) The agency must maintain documentation of payment rates and make it available to HHS upon request.